

**Child Adolescent Mental Health Division**  
**Utilization Management Program: Fiscal Year 2005**  
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## ***I. Utilization Management (UM) Program***

### **A. Overview**

The Child and Adolescent Mental Health Division (CAMHD) operates a system of care serving seriously emotionally and behaviorally disturbed youth requiring intensive mental health services. CAMHD strongly believes in the provision of services within the least restrictive environment, and takes every measure to ensure that the service needs of youth are accurately identified and that youth receive appropriate services in a timely manner that meet their identified treatment needs in home or home-like settings whenever possible. Utilization Management (UM) is a fluid process designed to meet the ever-changing needs of our service population and focuses on appropriate and evidence based services for youth at various levels of care. The Utilization Management Program also examines patterns and trends of service delivery to identify and address potential overutilization and underutilization of services, overly restrictive services, and the use of non-evidenced based interventions. The UM program is administered by the Family Guidance Centers (FGC) and the Clinical Services Office (CSO) of Central Administration. The Utilization Management Program and database are part of the CAMHD quality committee structure.

### **B. Objectives**

The objectives of the Utilization Management Plan are to:

1. Assure access to and availability of a wide array of needed services for eligible youth
2. Ensure adequacy of service availability through the maintenance of a sufficient, strong and reliable high quality provider network
3. Ensure youth are placed in the least restrictive setting that is appropriate
3. Identify and address underutilization
4. Identify and address overutilization
5. Support Coordination of Care
6. Enhance provider satisfaction with UM program
7. Gather and analyze utilization data, communicate findings and make appropriate recommendations for positive change

### **C. Purpose**

The purpose of the Utilization Management (UM) Plan is to ensure the provision of adequate and appropriate services to eligible youth and to enhance consistency in reviewing cases by providing a framework for clinical decision making.

#### **D. Utilization Management (UM) Committee**

The UM Committee is the body that reviews all UM data and makes recommendations for change in UM guidelines or strategies. The specific responsibilities of the UM Committee include the following:

1. Oversee utilization data review strategies and areas of focus
2. Review and analyze all UM reports to identify opportunities for improvement in the delivery, availability, or access of services and to identify UM achievements
3. Propose solutions to problems and concerns identified by utilization review activities
4. Establish procedures designed to achieve the goals and objectives of the UM plan
5. Recommend specialized studies
5. Maintain awareness of confidentiality in utilization management activities, decisions, and recommendations
6. Reviews and recommends changes to *Interagency Performance Standards & Practice Guidelines*

The UM Committee participants are the CAMHD Medical / Clinical Director (psychiatrist), CAMHD Research and Evaluation Specialist, a representative from the provider network, a parent, a Family Guidance Center Branch Chief, a Family Guidance Center Clinical Director (psychiatrist), and representatives from the Clinical Services Office, Performance Management Office, and Administration Office of CAMHD.

The Medical /Clinical Director provides clinical input as well as operational oversight into the committee activities. The Research and Evaluation Specialist facilitates data interpretation, study planning, and data review strategies. Each of the other representatives provides input as relevant to the respective stakeholders. Attendance may be in person or by teleconference. Quorum is defined as at least 50% of the committee members and voting may be done via email. If voting is done by email, the email documents are kept as official UM Committee minutes.

CAMHD's Quality Assurance and Improvement Program has also given the UM Committee the responsibility of monitoring access and availability of the provider network and network adequacy.

#### **E. Family Guidance Centers (FGC)**

The Family Guidance Centers are responsible for initial intake of youth, service planning, care coordination and generating any needed action letters. Each FGC is made up of administrative staff, mental health care coordinators, mental health supervisors, Branch Chief, Clinical Psychologist and a Clinical Director. Each staff plays a specific role in ensuring and promoting appropriate services to children and

families. The key components of care coordination are assessment, intensive case management, coordinated service planning, and engagement of youth and families in services. A care coordinator uses a coordinated service planning process to bring team members together to develop an integrated, comprehensive plan that identifies and addresses areas of need. Once the treatment needs are established, the care coordinator initiates appropriate service authorizations. The Family Guidance Center management structure provides oversight of clinical activities and assures access and compliance with the treatment plan provided and/or managed by the FGC. The Family Guidance Center monitors youth progress by communicating with providers involved in the youth's care. The FGC authorizes all levels of care with the exception of certain specialized services, Hospital Based Residential, and Community Based Residential High Risk I. The Branch Chief and Clinical Director can approve additional services above the stated thresholds in the *Interagency Performance Standards and Practice Guidelines*. The Clinical Directors are the only Family Guidance Center personnel authorized to deny, reduce or terminate services. The Clinical Director, along with input from Family Guidance Center staff, as needed, is responsible for concurrent review of all FGC youth. The Clinical Director also manages and coordinates medication when deemed necessary.

#### **F. Responsibilities of Central Office**

CAMHD's central office is composed of three sections; Performance Management; Administration and Clinical Services Office. Performance Management and Clinical Services Office have the most direct responsibilities related to the UM program. Performance Management provides monitoring of program and provider performance, is responsible for credentialing providers, certifies facilities, manages grievances and grievance appeals, tracks sentinel event and manages the Quality Assurance and Improvement Program for CAMHD. Performance Management has responsibility for implementing designated UM performance measures as part of the QAIP.

The Clinical Services Office (CSO) provides oversight for CAMHD clinical policies and procedures. CSO participates in the development and /or the review of clinical and utilization aspects of CAMHD documents and activities such as *the Interagency Performance Standards and Practice Guidelines*, provider contracts, policies and procedures, and Request for Proposals (RFP). The two primary functions of the Clinical Services Office are Practice Development and Resource/Utilization Management. Resource/Utilization Management produces reports, analyzes data and trends, determines the need for specialized services, facilitates the services for challenging youth, monitors utilization of services, approves initial and continued stays for specialized services, Hospital Based Residential and Community Based Residential High Risk I levels of care and participates in the development and implementation of newly identified services or levels of care. This office maintains oversight of actions and appeals.

## **G. Eligibility for Services**

Determinations of eligibility for services are made through a review at the Family Guidance Center level. This is done under the supervision of the MHS1, Branch Chief and Clinical Director. Eligibility for services includes any of the following criteria:

1. Youth age 3-21 years determined by the child's educational team as needing intensive mental health services in order to benefit from their education
2. Seriously Emotionally or Behaviorally Disturbed Youth age 3-21 years as assessed by MedQUEST plan psychiatrist
3. Youth in need of mental health crisis services
4. Youth involved in the Juvenile Justice system or determined to need mental health services by the Family Court Liaison Branch (FCLB)

## **H. Assessments**

Once the eligibility determination is made, the Family Guidance Center ensures that the assessments necessary to determine treatment needs are conducted or are current. Prior to out-of-home services, available clinical data such as, Child and Adolescent Functioning Assessment Scale (CAFAS), Achenbach System of Empirically Based Assessments (ASEBA), Child and Adolescent Level of Care Utilization System (CALOCUS), and Functional Behavioral Assessment (FBA), along with the family's or current caregiver's ability to adequately respond to the youth's need are reviewed and measurable goals are developed.

Information sources for assessments are gathered from a variety of sources including team discussions, interviews, records review, rating scales and specific skill assessments.

## **I. Service Planning**

In all cases, decisions made by IEP teams, CSP teams or other treatment planning teams will be the guiding factor for service planning. CAMHD procures mental health services that are deemed clinically necessary through contractual agreement with community provider agencies. Examples of processes and documents that support service planning include Individualized Education Plan (IEP); Behavioral Support Plan (BSP); Mental Health Treatment Plan (MHTP); Coordinated service Plan (CSP) and Modification Plan (MP).

## **J. Levels of Care and Frequency of Review**

CAMHD utilizes multi-tiered levels of care to ensure a broad service array is available to meet the needs of youth. The *Interagency Performance Standards and Practice Guidelines* describes each level of care in detail including service components, admission criteria, continued stay criteria, discharge criteria, service exclusions and clinical exclusions. Levels of care include:

1. CAMHD provides emergency services that are available 24-hours per day, seven days a week and include: 24-hour crisis telephone services, mobile outreach services, and crisis stabilization services. A licensed psychiatrist is on call in the event of medical or complex psychiatric related situations in need of consultation. Prior authorization for accessing emergency services is not required. Crisis bed stabilization services beyond three days requires continued stay authorization.
2. Intensive Home and Community Based Intervention (IIH). These services provided in the child's current living environment, are designed to stabilize and preserve the child's functioning and/or prevent the need for outside services. Initial authorization can be for up to four weeks after which concurrent reviews are monthly. Authorization for these services is done at the FGC.
3. Multisystemic Therapy (MST) is a time-limited, intensive family and community based treatment that addresses the multiple determinates of serious anti-social behavior and promotes positive behavior change in the youth's natural environment. Initial authorization can be up to five months after which concurrent reviews are monthly. Authorization for these services is done at the FGC with input from the MST system supervisor. Service extensions are approved by the Medical Director.
4. Therapeutic Foster Homes (TFH) are intensive community based treatment services provided to youth in a home setting who are capable of demonstrating growth in such a setting. Initial authorization can be for up to 3 months after which concurrent reviews are monthly. Authorization for these services is done at the FGC
5. Respite Homes offer safe, short-term and supportive environments for youth and structured relief to the parent / caregivers of these youth in order to reduce the risk of out-of-home services at a higher level of care. Initial authorization can be from two days to a maximum of five days. Authorization for these services is done at the FGC
6. Therapeutic Group Homes provide 24-hour care and integrated evidence-based treatment planning to youth whose needs can best be met in a structured program of small group living in a community-based setting. Initial

authorization can be up to three months after which concurrent reviews are monthly. Authorization for these services is done at the FGC.

7. Individualized Placements are programs that are uniquely developed for youth whose needs cannot be met by the existing services offered. Initial authorization can be for up to three months after which concurrent reviews are every two months. Clinical authorization for these services is done by the CSO Medical Director. However, other central office departments are required for approval of services to ensure financial, program monitoring and contractual issues are addressed.

8. Community Based Residential Programs provide 24 hour care and integrated service planning to youth whose needs require more structure or supervision than a therapeutic group home but whose needs are still for a structured program of small group living in a community based setting. Initial authorization can be for up to three months after which concurrent reviews are every two months. Authorization for these services is done at the FGC but may require CSO Medical Director authorization for extended stays (those over the established threshold and/or over average length of stay).

9. High Risk community Based Residential Program provides 24-hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending youth whose needs are for a structured program of small group living. Initial authorization is for up to three months after which concurrent reviews are every three months but increase in frequency to every two weeks for three months prior to the anticipated discharge date. Authorization for these services is done by the CSO Medical Director.

10. Hospital Based Residential services provide secure intensive inpatient treatment services to youth with severe emotional disturbance who required short-term hospitalization. Initial authorization is for up to approximately two weeks (can be expanded to accommodate three day weekends) after which concurrent reviews are at least every two weeks. Authorization for these services is done by the CSO Medical Director.

11. Out-of-State Settings– although this is not a separate level of care as they are usually CBR's, they are considered to be the most restrictive level of care because the youth is in a setting so far from home, family and community. Youth in these receiving these services are usually court ordered. Initial authorization for these services is done by the CSO Medical Director and the FGC reviews at least monthly thereafter.

Wrap Services is not a level of care but is a broad definition of situations where the youth is appropriate for an existing level of care but additional or supplementary services within that level of care in excess of usual contractual

expectations is provided. These services are not medically necessary. Authorization for these services is done at the FGC after review and approval by the CAMHD Chief.

## **K. Initial Authorization and Referral Process**

The FGC initiates referrals to appropriate service providers as indicated by the assessments and service plans. When conducting initial authorization review, efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate. The Care coordinator initiates prompt authorization of services to ensure access to routine services within 6 weeks. With the exception of emergency services (that includes emergent and urgent care) services require prior written authorization. Pre-authorizations for the most intensive levels of care including Hospital-Based Residential (HBR), High Risk Community-Based Residential and Out-of State must be recommended by the Family Guidance Center's treatment team including Branch Chief and Clinical Director and then are approved by the CSO Medical Director. All other out-of-home services are reviewed and approved based on necessity by the FGC Clinical Director.

Prior authorization for outpatient emergency and urgent services including 24-hour crisis phone service, mobile outreach and crisis stabilization is not required.

When making decisions concerning care, CAMHD does not employ or permit the employment of utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individual determination of medical necessity based on the needs of the recipient and his/her history.

## **L. Criteria**

CAMHD's criteria for admission, continued stay and discharge for every level of care is clearly delineated in the *Interagency Performance Standards and Practice Guidelines*.

## **M. Concurrent Review**

Section J – Level of Care and Frequency of Review describes the frequency of concurrent review for the various levels of care. CAMHD's criteria for continued stay for every level of care is clearly delineated in the *Interagency Performance Standards and Practice Guidelines*. When conducting concurrent review, efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate. The process used for concurrent review is that the FGC conducts concurrent review for IIH, MST, TFH, TGH and CBR services. The CAMHD Medical Director is available for consultation as needed.

For Out-of-State, HBR, and High Risk CBR services, concurrent review is a joint process between the FGC and the CSO Medical Director. This is accomplished by the FGC reviewing all necessary information including mental health status; progress; medications and response to medications; treatment plan goals and progress toward achieving those goals; diagnosis; relevant medical issues; discharge plan input from treating physician and current needs of the youth. This information is then reported to the CAMHD Medical Director. The CAMHD Medical Director's signature is required to approve continued stays for these higher levels of care. If there are any questions, concerns or discrepancies the CAMHD Medical Director may dialogue with the FGC and/or provider of services. The FGC Clinical Director may also dialogue with the provider of services. This dialogue process occurs especially if any of the following occur:

- a) indications that the youth does not meet continued stay criteria
- b) treatment plan that seems inappropriate or insufficient
- c) medication concerns
- d) quality of care concerns
- e) lack of effective discharge planning
- f) lack of progress

## **N. Denial or Reduction of Services**

If it is determined that a level of care or continued stay requested is not appropriate, the FGC Clinical Directors or CAMHD Medical Director are the only ones authorized to deny authorization for services. If this does occur, a letter is generated to the youth, parent or guardian, and provider (if applicable) informing them of the decision and reminding them of their appeal rights.

## **O. Appeals Process**

CAMHD Policy & Procedure 80.604 describes the appeal process in detail. All families are notified of their rights, including appeal rights, in the *Consumer Handbook*.

If a service is going to be denied, stopped, or reduced, the youth, parent or guardian, and provider (if applicable) will receive a letter at least ten calendar days before the proposed action giving the reasons for the decision and reminding them of their appeal rights. If the youth, parent or guardian, or provider do not agree with the decision, an appeal can be filed within 30 calendar days. If an appeal is filed verbally, the Clinical Services Office must receive the written appeal within 10 calendar days of the verbal appeal. If needed, the Clinical Services Office will assist in writing the appeal.

Within 5 business days of receipt of the appeal (verbally or in writing), the appellant is sent a letter stating that their appeal has been received and is being reviewed.

Two psychiatrists who were not party to the original decision will review the appeal. Within 30 calendar days of filing the appeal (verbal or written) the appellant will receive a

written decision. If the appellant still does not agree with the decision, a final appeal may be filed.

If a Quest appellant still does not agree with the decision, they may appeal one last time to the Department of Human Services. The appellant also has the right to file an external review with the Insurance Commissioner. Non-Quest appellants may submit a final appeal to the CAMHD Clinical Services Office Appeal Board.

If requested in writing by the appellant, CAMHD will continue services while the appeal is being reviewed. However, if an action is upheld, the appellant may be responsible for payment of the services provided during the period of time that the appeal was being processed.

If more time is needed by the appellant or CAMHD, either party may request a 14 day extension to the appeal timelines.

A quick review of the appeal (expedited appeal) will be made if the health or well being of a youth is at risk. This review will take place within 3 business days of receipt of the appeal or within 24 hours if the situation is life threatening. The appellant will receive immediate verbal notice of the decision with written notice within 2 calendar days of the decision.

## **P. Review of Utilization Policies, Criteria and Guidelines**

The Evidence-Based Services Committee (EBS) reviews the *Interagency Performance Standards and Practice Guidelines* regularly. The Utilization Management Committee informs the EBS committee of changes as needed. Both of these committees have parent and provider representatives in order to promote and include community feedback in the decision-making process. CAMHD Clinical Services Office, based on review of the scientific evidence summarized by the EBS Committee or recommendations by the Utilization Management Committee may choose to draft proposed updates to the practice standards or guidelines. Executive Management Team of CAMHD reviews and has the authority to approve changes. The Utilization Management Program reviews, develops and revises policies and procedures specific to utilization management practices. All CAMHD policies and procedures are reviewed by the Policy and Procedure Committee and approved by the CAMHD Chief prior to implementation.

## **Q. Coordination of Care**

Policy & Procedure 80.702 “Care Coordination” describes this process in detail. Care Coordination consists of functions usually provided by the FGC to facilitate timely access and implementation to services. The Care Coordinator (CC) is the central point of contact and the individual primarily responsible for ensuring that needed services, interventions and strategies are identified and delivered in a coordinated and timely manner and in partnership with families. Care Coordination activities include but are not limited to

- a) ensuring that assessments are conducted that identify the strengths and needs of the youth and family
- b) convening team meetings to conduct strength-based planning via the Coordinated Service Plan (CSP) process
- c) documenting the CSP
- d) implementing the CSP
- e) monitoring and evaluating the effectiveness of the CSP and services
- f) revising the CSP as needs change
- g) ensuring that Child and Adolescent Service System Program (CASSP) Principles guide service planning

Management at the Family Guidance Centers conducts quarterly chart audits to ensure timeliness and appropriateness of service delivery. Performance Management section also conducts performance monitoring internal reviews.

## **R. Access and Availability**

To ensure timely access to care, CAMHD has established standards for access to routine, urgent, and emergent care. The standards are consistent with the expectations and requirements of regulatory and accrediting bodies: routine care, 6-weeks; urgent care, 24-hours; and emergent care, immediate. To ensure availability of care, network adequacy reports are generated and analyzed. In order to monitor access and availability, the UM Program reviews a variety of data reports (Please refer to UM workplan)

The reports are reviewed by the UM Report Subcommittee for accuracy and consistency, and then by the Utilization Management Committee. The UM Committee may make recommendations for improvement through the CAMHD committee structure. The reports are disseminated to CAMHD management and Family Guidance Center staff.

## **S. Underutilization and Overutilization**

The Utilization Management program identifies and addresses underutilization and over utilization. This is accomplished by reviewing data from a variety of reports and conducting clinical studies. (Please see UM Workplan)

Findings are reviewed and analyzed by the utilization management committee. Recommendations from the analysis are made through the CAMHD committee structure.

The contract extension flow chart process is designed to help the CSO to perform an analysis of practice patterns related to bed capacity, length of stay, waitlists, and the ability to create additional beds. This method is a tool that can guide CAMHD in the decision making process to extend, terminate or modify the number of contracted beds.

## T. Provider Satisfaction and Network Adequacy

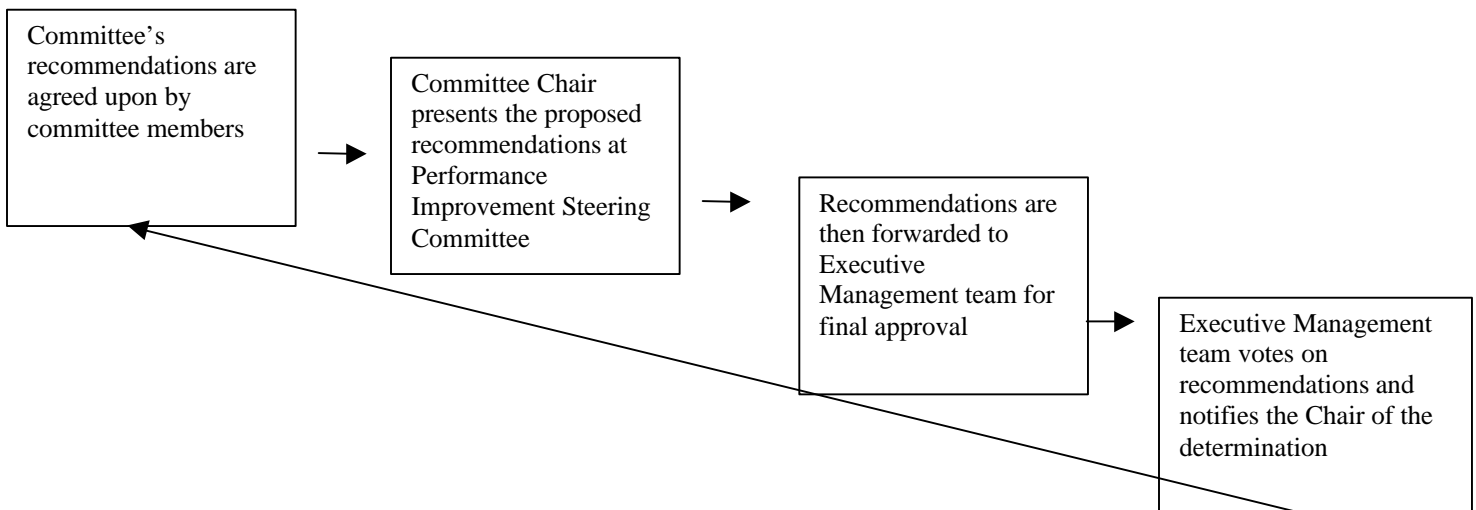
The QAIP describes the use of provider satisfaction as it relates to the UM Program and provider profiling. The Provider Relations Specialist collects and disseminates feedback from the provider satisfaction with UM surveys to the Performance Improvement Steering Committee (PISC) members. The UM Chair sits on the PISC. All PISC members communicate the UM survey results to their respective staff and/or relevant committees.

Network Adequacy is also evaluated via reports as indicated in the UM Workplan.

## U. CAMHD Committee Structure and Change Process

Upon review of utilization data, the Utilization Management Committee may be satisfied with the data and/or may recommend strategies for using the data to guide key decisions or may determine further data analysis is necessary or may make specific recommendations to CAMHD management for improvement action as appropriate.

Formal information sharing throughout CAMHD occurs through the committee structure. CAMHD's committees, including the Utilization Management Committee, review information and submit findings and recommendations to the Performance Improvement Steering Committee. Performance Improvement Steering Committee may accept or modify the recommendations. The PISC recommendations then forwarded to the Executive Management Team for final review and action. The process is repeated as necessary.



## ***II. Utilization Management Work Plan – FY 2005***

The UM Work Plan looks at a variety of indicators to determine progress toward objectives of the UM Plan. Five areas are examined: (1) Access and Availability, (2) Underutilization, (3) Over Utilization, (4) Coordination of Care, and (5) Provider Communications and Satisfaction. For each objective, a specific topic, methodology, measurable outcome, and time frame is specified. The Work Plan is a working document that is subject to review and revision by the UM Committee.

## Utilization Management Work Plan – FY 2005

### A. Access and Availability

Topic	Rationale	Study Pop.	Type	Methodology	Measurable Objective	Contract Years	Accountability	Oct 04	Nov 04	Dec 04	Jan 05	Feb 05	Mar 05	Apr 05	May 05	Jun 05	July 05	Aug 05	Sep 05
Service Gaps	Availability of Care	P	C	Monthly Indicator	98% of consumers receive service within 30 days of request	2004-2005	FGC/CSO Resource Management	R	X	X	R	X	X	R	X	X	R	X	X
Service Mismatches	Availability of Care	P	C	Monthly Indicator	95% of consumers receive specific services in CSP within 30 days	2004-2005	FGC/CSO Resource Management	R	X	X	R	X	X	R	X	X	R	X	X
Bed Availability	Availability of Care	P	C	Provider Census Database	≥3% bed vacancy rate system-wide	2004-2005	CSO	X	X	R	X	X	X	X	X	R	X	X	X
Registration Date to 1 <sup>st</sup> receipt of services	Access to Routine Care	P	C	Annual CAMHMIS	100% ≤ 30 days Benchmark Increase Rate to 10% of Gap	2004-2005	PM/RES	X	X	X	X	X	X	X	X	R	X	X	X
Time from Mobile Outreach Assessment to Crisis bed placement	Access to Urgent Care	P	C	Provider Records	85% on-site response within 45 minutes or usual transport time	2004-2005	PM	X	X		R	X	X	X	X		R	X	X
Time from Mobile Outreach Referral to Mobile Outreach Arrival	Access to Emergent Care	P	C	Provider Records	85% on-site response within 45 minutes or usual transport time	2004-2005	PM	X	X		R	X	X	X	X		R	X	X
Hotline Responsiveness	Access to Care	P	C	Provider Records	85% Hold Time ≤ 15 sec	2004-2005	PM	X	X	X	R	X	X	R	X	X	R	X	X
Hotline Responsiveness	Access to Care	P	C	Provider Records	85% Number of Rings ≤ 3 (or ≤ 10 sec)	2004-2005	PM	X	X	X	R	X	X	R	X	X	R	X	X

R = Report  
 P = Population Measurement Monitor  
 FS = Focus Study on Select Members  
 C = Clinical Study  
 PM = Performance Management Sections  
 CSO = Clinical Services Office  
 FGC = Family Guidance Centers  
 RES = Research and Evaluation Specialist  
 ASO = Department of Health Administrative Services Office  
 LRE = Least Restrictive Environment

S = System (Non-Clinical) Study  
 I = Intervention period  
 X = Data collection period  
 PS = Performance Improvement Project  
 IHH = Intensive In-Home Services  
 OOH = Out-of-Home Services  
 OOS = Out-of-System Services  
 CHR = Community High-Risk Services  
 HBR = Hospital-based Residential Services

## B. Underutilization

Topic	Rationale	Study Pop.	Type	Methodology	Measurable Objective	Contract Years	Accountability	Oct 04	Nov 04	Dec 04	Jan 05	Feb 05	Mar 05	Apr 05	May 05	Jun 05	July 05	Aug 05	Sep 05
Appointments after Discharge (e.g., services within 30 days of CBR discharge)	↑ Risk Under-utilization Follow-Up Services	P	C	CAMHMIS	80% of Youth Date of 1 <sup>st</sup> Accepted Record or date of OOS service within 30 days of CBR discharge date or last CBR Accepted Record	2004 – 2005	CSO/RES	X	X	R	X	X	X	X	X	R	X	X	X
Utilization of Substance Abuse Services	↑ Risk Under-utilization	P	C	CAMHMIS	60% of youth with Substance-Related Diagnosis with Substance Use Endorsed as Target on Provider Monthly Summary Baseline Measurement	2004 – 2005	CSO/RES	X	X	R	X	X	X	X	X	R	X	X	X

## C. Overutilization

Topic	Rationale	Study Pop.	Type	Methodology	Measurable Objective	Contract Years	Accountability	Oct 04	Nov 04	Dec 04	Jan 05	Feb 05	Mar 05	Apr 05	May 05	Jun 05	July 05	Aug 05	Sep 05
Intensive Home and Community Based Services Length of Services	Over-utilization	P	C	CAMHMIS	≥ 60% of consumers receiving IIH Services have Length of Stay within IPSPG Standards	2004 – 2005	CSO: Resource Management	X	X	X				R					
Length of Stay	Over-utilization	R	C	CSO Provider Database	≥ 50% of consumers in HBR, CBR and TGH LOC will have LOS within IPSPG Standards Baseline Measurement	2003-2004	CSO: Resource Management	R (FY 04)	X	X	X	X	X	X	X	X	X	X	X

## D. Coordination of Care

Topic	Rationale	Study Pop	Type	Methodology	Measurable Objective	Contract Years	Accountability	Oct 04	Nov 04	Dec 04	Jan 05	Feb 05	Mar 05	Apr 05	May 05	Jun 05	July 05	Aug 05	Sep 05
% of Consumers linked to Physical Health Services	↑ Risk Coordination of Care	P	C	Document Review	90% Benchmark ↑ Rate to 10% of GAP	2004 – 2005	FGC/ PM				X	X	X		R				
Care Coordination Quality	↑ Risk Coordination of Care	FS	C	Internal Review	≥ 85% of Reviewed Cases with Acceptable Care Coordination Rating Updated Semi-Annually	2004 – 2005	PM: Program Monitoring	X	X	X	R	X	X	R					
Coordinated Service Plan (CSP) Timeliness	Timely Planning Coordination of Care	P	C	Record Review	≥ 85% of Consumers with CSP Updated Quarterly ↑ Rate to 10% of GAP	2004 – 2005	PM	X	X	X	R	X	X	R					

## E. Provider Satisfaction / Network Adequacy

Topic	Rationale	Study Pop.	Type	Methodology	Measurable Objective	Contract Years	Accountability	Oct 04	Nov 04	Dec 04	Jan 05	Feb 05	Mar 05	Apr 05	May 05	Jun 05	July 05	Aug 05	Sep 05
Provider Satisfaction with UM	Provider Satisfaction	R	S	Survey	80% of Providers Report Satisfaction with UM Baseline Measurement	2004 – 2005	Administration: Provider Relations	R		X	X	X		R		X	X	X	
CBR/ TGH/TFH Provider Practice Patterns	Network Adequacy / Provider Practice Patterns	R	C	Provider Census Database	Complete an analysis of beds used and LOS for all CBR/ TGH and TFH providers	2004-2005	CSO: Resource Management	R CBR			R TGH				R TFH				
To Be Determined	Network Adequacy				To Be Determined	2004 – 2005	CSO: Resource Management												

